STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL PROGRAM COST REPORT

INTERMEDIATE CARE FACILITY
FOR THE DEVELOPMENTALLY DISABLED

Facility Name: _____

Service Level: ☐ **Habilitative** ☐ **Nursing**

Medi-Cal Provider Number: _____

Reporting Period: From _____ To _____

INTERMEDIATE CARE FACILITY COST REPORT FOR THE DEVELOPMENTALLY DISABLED (HABILITATIVE OR NURSING) GENERAL INFORMATION AND CERTIFICATION

1. Name of Facility	2. State License Number	3. Medi-Cal Provider Number
4. Street Address	5. City	6. ZIP Code
7. Mailing Address	8. City	9. ZIP Code

10. Administrator

11. Report Contact Person	12. E-mail Address	13. Phone Number
14. Mailing Address: Street or P.O. Box	15. City	16. ZIP Code
17. Reporting Period Began	18. Reporting Period End	
19. Name of Home Office (If Applicable)		20. Home Office Phone Number

21.

CERTIFICATION

I, _____, certify under penalty of perjury as follows:

That I am an official of _____and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and Institutions Code.

Signature _____ Date _____

Title _____

Address _____

Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed, are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.

22. Mail the original and three (3) copies to:

U.S. Mail

California Department of Health Care Services
Audits and Investigations
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 650-6696

FedEx, UPS, etc.

California Department of Health Care Services
Audits and Investigations
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
Sacramento, CA 95814

Is this report being filed as a result of change in ownership? ☐ Yes ☐ No

NOTE: A COMPLETED REPORT IS REQUIRED FOR EACH LICENSED FACILITY

Facility Name	Fiscal Year End

SECTION A—REQUEST FOR INFORMATION

1. Are financial statements (income statement, balance sheet, etc.) available for the cost reporting period? ☐ Yes ☐ No
2. Were any assets disposed of during the reporting period? ☐ Yes ☐ No
3. Does your facility maintain patient trust accounts? ☐ Yes ☐ No

If yes:

a. Balance of trust account at the beginning of period . . . . . .$_____

b. Total deposits during reporting period . . . . . .$_____

c. Total expenditures from trust account. . . . . .$_____

d. Balance at the end of reporting period . . . . . .$_____

SECTION B—LICENSEE DESCRIPTION

	Type of Control	X	Legal Organization	X	
01	Church Related Not-For-Profit		Corporation		07
02	Other Not-For-Profit		Division of a Corporation		08
03	Investor Owned For-Profit		Partnership		09
04	Owner/Operator For-Profit		Proprietorship		10
05			Other (Specify)		11

SECTION C—FACILITY CENSUS

Line	Total Statistics	Medi-Cal Fee for Service	Medi-Cal Managed Care	Other	Total
1	Licensed Beds—Beginning of Period				
2	Licensed Beds—End of Period				
3	Client Days				0
4	Discharges Including Deaths				0
5	Admissions				0

Facility Name	Fiscal Year End

SECTION D—STATEMENT OF RELATED ORGANIZATIONS

Is the facility part of a chain organization? (For definition, see Section E instructions.) ☐ Yes ☐ No

If yes, please complete the following:

Home Office or Related Organization	Percent of Ownership

SECTION E—STATEMENT OF HOME OFFICE COSTS

Are any costs included during this reporting period a result of transactions with the home office (parent company)? If yes, you are required to file a home office cost report (See instructions). Please provide the information which is the result of transactions with a related organization. ☐ Yes ☐ No

Account	Item	Amount
		$

SECTION F—STATEMENT OF COMPENSATION TO OWNERS

Name of Owners	If Employed by Facility: Title and Function	Owners Investment Percentage	Average Hours Worked Per Week	Compensation	
				Current Fiscal Year	Prior Fiscal Year
		0.00%		$	$
		0.00%			
		0.00%			
		0.00%			

SECTION G—STATEMENT OF COMPENSATION PAID TO ADMINISTRATOR (OTHER THAN OWNERS OR QMRP)

Name	Title	Weekly Average Hours Devoted To Facility	Compensation	
			Current Fiscal Year	Prior Fiscal Year
			$	$

Facility Name | Fiscal Year End

SECTION H—STATEMENT OF INCOME AND EXPENSE WITH RECLASSIFICATION AND ADJUSTMENTS

Line Number	(1) Description	Account Number	(2) Amount	(3)* Reclassification and Adjustments	(4) Total Amount (Col. 2 & 3)
	Revenues: Client Services:				
005	Medi-Cal Per Diem	4010	$	$	$ 0
006	Adult Day Services & Related Transportation				0
010	Private	4020			0
015	Other	4030			0
020	Subtotal (Lines 005 to 015)		0	0	0
	Deductions From Revenue:				
025	Contractual and Other Deductions	4040			0
030	Net Client Service Revenue (Line 020 – 025)		0	0	0
035	Other Operating Revenue	4050			0
040	Net Operating Revenue (Line 030 + 035)		0	0	0
	Expenses: Client Services				
	Basic Facility Cost				
	Property Expenses:				
045	Depreciation and Amortization	5010			0
050	Leases and Rentals	5020			0
055	Real Property Taxes	5030			0
060	Personal Property Taxes	5040			0
065	Mortgage Interest	5050			0
070	Property Insurance	5060			0
075	Total Property Expenses (Lines 045 to 070)		0	0	0
	General Home Expenses:				
080	Home Operations and Maintenance	5070			0
085	Utilities	5080			0
090	Client Transportation (excluding Adult Day Services)	5090			0
095	Dietary	6000			0
100	Personal Care and Laundry	6010			0
105	Total General Home Expenses (Lines 080 to 100)		0	0	0
110	Total Basic Facility Cost (Line 075 + 105)		$ 0	$ 0	$ 0

* From Page 5, Column 1.

Facility Name | Fiscal Year End

SECTION H—STATEMENT OF INCOME AND EXPENSE WITH RECLASSIFICATION AND ADJUSTMENTS (Continued)

Line Number	(1) Description	Account Number	(2) Amount	(3)* Reclassification and Adjustments	(4) Total Amount (Col. 2 & 3)
	Direct Care Staff Costs:				
115	QMRP Salaries	6020	$	$	$ 0
120	QMRP Fringe Benefits	6025			0
125	Lead Salaries	6030			0
130	Lead Benefits	6035			0
135	Aides Salaries	6040			0
140	Aides Benefits	6045			0
145	Other Salaries	6050			0
150	Other Benefits	6055			0
155	Total Client Care Staff Cost (Lines 115 to 150)		0	0	0
	Consultant Costs:				
160	Dietitian Consultant	6060			0
165	Speech Pathology Consultant	6070			0
170	Physical Therapy Consultant	6080			0
175	Occupational Therapy Consultant	6090			0
180	Pharmacist Consultant	7000			0
185	Nurse Consultant	7010			0
190	Psychologist Consultant	7020			0
195	Physician Consultant	7030			0
200	Recreational Consultant	7040			0
205	Social Service Consultant	7050			0
210	Other Consultant	7060			0
215	Total Consultant Cost (Lines 160 to 210)		0	0	0
	Administrative Costs:				
220	Administrative Salaries**	7070			0
225	Administrative Fringe Benefits	7075			0
226	Quality Assurance Fees (excluding Adult Day Services)	7080			0
230	Other General and Administrative*** (excluding Adult Day Services)	7080			0
235	Total Administrative Cost (Lines 220 to 230)		0	0	0
	Non-client Care Expense:				
240	Non-program Services	7090			0
241	Adult Day Services & Related Transportation				0
245	Total Expenses (Lines 110, 155, 215, 235, 240, 241)		0	0	0
250	NET INCOME (Line 040 – 245)		$ 0	$ 0	$ 0

* From Page 5, Column 1.
** List only direct administrative salaries incurred at the facility level
*** List allocated administrative costs on Line 230

Facility Name	Fiscal Year End

SECTION I—RECLASSIFICATION AND ADJUSTMENTS OF REVENUES AND EXPENSES

Line	Account Description	(1) Amount Increase (Decrease)	(2) Statement of Income Line Number	(3) Explanation of Reclassification of Adjustment
1		$		
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31	TOTAL	$ 0		

AMOUNTS TO BE TRANSFERRED: Transfer all entries from Column 1 to Page 4 or 4.1, Column 3.

BASIS FOR RECLASSIFICATIONS AND ADJUSTMENTS: It is necessary to analyze some accounts in order to ensure that various items and amounts are properly classified in order to effect a proper cost distribution. Please refer to instructions.

SECTION J—LABOR REPORT

Number	Description	(1) Benefits	(2) Salaries	(3) Total Hours	(4) Average Hourly Wage
1	QMRP	$	$		$
2	Lead				
3	Aides				
4	Other Salaries				
5	Subtotal (Lines 1 to 4)	0	0	0.00	0.00
	CONSULTANT COSTS:				
6	Dietitian Consultant				
7	Speech Pathology Consultant				
8	Physical Therapy Consultant				
9	Occupational Therapy Consultant				
10	Pharmacist Consultant				
11	Nurse Consultant				
12	Psychologist Consultant				
13	Physician Consultant				
14	Recreational Consultant				
15	Social Service Consultant				
16	Other Consultant				
17	Subtotal (Lines 6 to 16)	0	0	0.00	0.00
	ADMINISTRATIVE COSTS*				
18	Administrative Salaries*				
19	GRAND TOTAL (Lines 5, 17, & 18)	$ 0	$ 0	0.00	$ 0.00

* List only direct administrative costs. Do not include home office administrative cost.

INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED (HABILITATIVE OR NURSING)

GENERAL INSTRUCTIONS FOR COMPLETING COST REPORT FORMS

1. One report must be submitted for each licensed facility.

2. One original and three copies of the report must be legibly completed and submitted within five months after the close of the facility's fiscal year.

3. The report must be legibly completed by typewriter or black ink. Do not use blue ink or pencil.

4. In order to be considered complete, all required pages must be completed in accordance with the instructions which follow.

5. No line or column descriptions are to be changed under any circumstances. If an item does not conform to the cost centers specified, include the item in the "Other" category.

6. **All dollar amounts are to be reported in whole dollars. Do not include cents.**

7. All financial records supporting the report should follow generally accepted accounting principles and rules, CMS Publication 15-1, California Administrative Code, Title 22 requirements, and Medi-Cal Provider Manual for Long-Term Care.

ICF/DD (H OR N) COST REPORT INSTRUCTIONS

PAGE 1—GENERAL INFORMATION AND CERTIFICATION: The purpose of this page is to collect licensee information, the licensee mailing address, the name of the person to contact for necessary information, and to have the contents of the report certified. A licensee is defined as a legal entity, e.g., the organization to which the actual license is issued.

1. Enter legal name of licensee.
2. Enter state license number.
3. Enter Medi-Cal provider number.
4. Enter facility street address.
5. Enter facility city.
6. Enter facility ZIP code.
7. Enter mailing address where official correspondence is to be sent if different from facility.
8. Enter mailing address city.
9. Enter mailing address ZIP code.
10. Enter name of administrator. This should be the person who oversees the overall daily operations of one or more facilities.
11. Enter name of person to contact to answer questions about the report.
12. Enter contact person's e-mail address.
13. Enter contact person's phone number.
14. Enter mailing address of contact person.
15. Enter city of contact person.
16. Enter ZIP code of contact person.
17. Enter first day, month, and year covered by the cost report.
18. Enter last day, month, and year covered by the cost report.
19. Enter name of home office, if applicable.
20. Enter home office phone number.

21. Certification must be signed by either the Administrator, Controller, Corporate Officer, or member of the Board of Directors. The official signing the report must have the legal capacity to make commitments for the organization.
22. Indicate if the report is being filed as a result of a change in ownership.

SECTION A—REQUEST FOR INFORMATION: Complete questions 1, 2, and 3 by marking the appropriate box. If the answer to question 3 is yes, then enter the requested trust fund information.

SECTION B—LICENSEE DESCRIPTION: Place an "X" in the appropriate column indicating the type of control and the legal organization of the facility.

SECTION C—FACILITY CENSUS

Line 1: Enter total number of licensed beds at beginning of report period.

Line 2: Enter total number of licensed beds at the end of the report period.

Line 3: Enter the total number of participant days during the cost reporting period that were billed to the Medi-Cal Fee for Service programs. If the total number of participant days during the cost reporting period were billed to Medi-Cal Managed Care days, enter it on the Medi-Cal Managed Care column. In the column marked "Other," enter the number of participant days during the cost reporting period that were billed to private pay or non-Medi-Cal participants. **(If not completed, cost report may be considered incomplete and subject to rejection.)**

Line 4: Enter the number of Medi-Cal discharges. Enter the number of discharges other than Medi-Cal in the column marked "Other."

Line 5: Enter the number of admissions made during the reporting period.

SECTION D—STATEMENT OF RELATED ORGANIZATION: Complete question by marking the appropriate box. If the answer to Section D is yes, then enter the name of the "Home Office or Related Organization" and "Percent of Ownership."

SECTION E—STATEMENT OF HOME OFFICE COSTS: Complete question by marking the appropriate box. If the answer is yes, then you are required to file a home office cost report.

A home office cost report is required when costs are included on the cost reports which are the result of transactions with a related entity, such as an administrative office, also referred to as a home office. Typically, the home office completes the administrative tasks for one or more facilities. These tasks could include bookkeeping, billing, accounts payable, purchasing, transportation, payroll, etc. The purpose of the home office cost report is to allocate the home office cost to the facilities. If home office costs are included on your cost report and you have not received a blank copy of the home office cost report, please contact DHCS, Financial Audits Branch. The address and phone number are on the bottom of Page 1.

Enter the account, item, and amount of home office cost in the appropriate column. For example:

Account	Item	Amount
Other Gen. & Admin.	H.O. overhead—rent, utilities, etc.	$4,500

Note: Allocated home office costs should also be reported on page 5. Reclassifications and Adjustments of Revenues and Expenses—Section I of the cost report. Refer to the home office cost report instructions for cost allocation guidelines.

SECTION F—STATEMENT OF COMPENSATION TO OWNERS: Enter the name(s) of the owners, their title and function if employed by the organization, percent of ownership, average number of hours worked per week, and compensation paid for the current fiscal year, and for the prior fiscal year.

SECTION G—STATEMENT OF COMPENSATION PAID TO ADMINISTRATOR (OTHER THAN OWNERS OF QMRP): Complete schedule with requested information for the administrator who is neither owner nor QMRP.

SECTION H—STATEMENT OF INCOME AND EXPENSE WITH RECLASSIFICATIONS AND ADJUSTMENTS: These pages are a summation of an ICF/DD (H or N) facility's income and expenses presented in income statement form.

Column 1—Description: This column is a description of each necessary line item account. The costs and revenues contained in each of these numbered accounts are defined in the Chart of Accounts.

Column 2—Amount: If you are using the recommended Chart of Accounts, list the fiscal year end account balances from the general ledger. If you are not, you must group your costs to agree with the cost report accounts. See the Description of Accounts for details of costs to be included in each account.

Column 3—Reclassification and Adjustments: Post reclassifications and adjustments including home office cost from page 5, column 1.

Column 4—Total Amount: Sum of columns 2 and 3.

PAGE 4

Lines 005-015: Revenue must be reported at usual and customary charges. On line 006 the reimbursement for the Adult Day Services and Related Transportation as detailed in the Welfare and Institutions Code 14132.925 (b) (1) should be included.

Line 025: Contractual and other deductions are the differential, if any, between the amounts of the facility's established daily rate and the amount received from third-party agencies.

Line 035: Include revenues such as earned interest, grants, regional center revenues, donations, etc.

Line 045: List depreciation on owned homes and equipment, amortization of leasehold improvements and start-up costs. Equipment includes tables and chairs, kitchen equipment, and various other furnishings. Start-up costs should be amortized over a five-year period. Note: This line item should ***not*** include depreciation of a home-owned van which would be reported on line 090-Client Transportation. Generally, asset lives should conform to the American Hospital Association estimated useful lives.

Line 050: Includes normal monthly lease or rental payments related to the physical property of the facility

Line 055: Include real property taxes paid to a government agency.

Line 060: Include personal property taxes paid to a government agency.

Line 065: If the facility is making monthly payments for the building they occupy, report the amount of mortgage interest which is included in the payment.

Line 070: Include cost of insurance payments for protection against property-related liabilities. This includes fire, flood, earthquake, and liability insurance.

Line 080: Include cost of facility gardening, minor repairs, and housekeeping supplies, e.g. light bulbs, safety equipment, etc.

Line 085: Include payments for gas, electricity, water, garbage, telephone, or any other property-related utility.

Line 090: Include costs associated with a facility-owned or leased vehicle, vehicle insurance, gasoline, maintenance, vehicle interest, vehicle depreciation, and purchased services and bridge tolls. These costs should be net of regional center reimbursement. Exclude that portion of costs pertaining to personal use. Documentation is required to establish the business use of a personal vehicle. The minimum requirement is a log indicating the date, purpose, and mileage of each trip.

Line 095: Include costs associated with food, kitchen supplies, and the costs of facility purchased meals.

Line 100: Include costs associated with client haircuts (excluding perms and special styling); weekend recreational outings and socialization experiences; and home linens and regular laundering care of clients' personal garments. Note: Do not include dry cleaning or special treatment for garments needing this care when the regular laundry services are not appropriate.

PAGE 4.1

Lines 115-215: This segment reports wages and benefits for the entire cost reporting period for salaried and contracted staff. Benefits should include such items as employer portion of taxes, unemployment insurance costs, sick leave and vacation, and other employer-paid benefits.

Line 220: Include salaries of administrator, office assistants, secretary, billing clerk and bookkeeper/accountant.

Line 225: Report the fringe benefit costs associated with the administrative staff including employer paid taxes, unemployment insurance, health insurance, sick leave and accrued vacation, and other employer-paid benefits.

Line 226: Include Quality Assurance Fee Paid in accordance with Health and Safety Code 1324.

Line 230: Include postage, printing, legal fees, and telephone charges resulting from administering the operations of the facility's business excluding the cost associated with Adult Day Services and related transportation.

Line 240: Include costs associated with providing services not related to ICF/DD (H or N) program or Adult Day Services and related transportation. This line should include costs, such as workshops.

Line 241: Include cost associated with providing services pertaining ONLY to Adult Day Services and related transportation as specified in Welfare and Institutions Code Section 14132.925 (b)(1). These consist of:

1. Direct Adult Day Services cost and related transportation costs.
2. Regional center's administrative costs associated with making disbursement on behalf of the ICF/DD Provider for Adult Day Services.
3. Salaries cost associated with ICF/DD's administrative staff responsible for performing the duties related to Adult Day Services.
4. Quality Assurance Fee paid associated with Adult Day Services ONLY in accordance with Health and Safety Code 1324. (Note: The Quality Assurance fee for Adult Day Services is remitted quarterly to DHCS)

PAGE 5—RECLASSIFICATIONS AND ADJUSTMENTS OF REVENUES AND EXPENSES

Reclassification: A reclassification is defined as an accounting entry which transfers costs from one account to another. Reclassifications will be necessary when revenue or expenses have been improperly classified. For example, building depreciation may have been included in an administrative account and needs to be transferred (reclassified) to a property related account. State explanation for the reclassification(s) in column 3.

Adjustments: Adjustments are defined as transactions which must be made to eliminate non-reimbursable costs or to abate revenues received which are actual recoveries of costs through sales. For example, the cost of fund-raising activities is not a reimbursable expense under the State ICF/DD (H or N) program. Any costs associated with fundraising which are included in general ledger expenses must be removed through an adjustment on page 5. When the cost of a non-reimbursable activity is removed, so should any related revenue. Also, any revenues received for such items as sale of scrap, or salvage, should be used to reduce the related expense. State adjustment explanations in column 3.

PAGE 6—LABOR REPORT

This report should reflect only direct costs incurred at facility level.

Column 1—Benefits: Report employee benefits and where applicable, consultant benefits. Include such items as employer portion of taxes, unemployment insurance costs, paid sick leave and accrued vacation, and other employer paid benefits.

Column 2—Salaries: Report salaries and wages for the entire cost report period for salaried and contracted staff.

Column 3—Total Hours: Report hours actually spent providing required services. Do not include vacation, sick leave, holidays, or other paid time off. If a staff position is both salaried and contracted, use a slash mark to separate hours between salaried and contracted. Report salaried hours first.

Column 4—Average Hourly Wage: Report gross average hourly wage excluding benefits. If a staff position is both salaried and contracted, use a slash mark to separate average hourly wage. Report salaried position first.